MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING FORM

Form TR-002
Revised 5/08

Reporting Facility	Abstracted By	Date Abstracted	Date Received by MCTR

PATIENT INFORMATION

Facility # Accession # Sequence # Date First Contact Medical Record Number

Name of Patient Last First Middle Maiden Alias | Primary Payer

Social Security Number	Date of Birth	Facility Referred From	Facility Referred To

Race	Hispanic Origin	Sex	Age	Marital Status	Name of Spouse/Parent	Place of Birth

Physical Address No & Street City County State Zip Code

Telephone Number	Family History of Cancer (Who/Type)	Tobacco History	Alcohol History

Usual Occupation	Usual Industry

Follow-Up Contact - Name (not spouse) Relationship No & Street City State Zip Code Telephone Number

CANCER INFORMATION

Date of Initial Diagnosis	Primary Site Laterality	Other Primary Tumors

Place of Diagnosis (if diagnosed elsewhere, please describe place)

☐ This Hospital ☐ Other Hospital
☐ Physician's Office ☐ Unknown ☐ Other _____

Diagnostic Confirmation

☐ Histology ☐ Cytology ☐ Microscopic ☐ Lab Test
☐ Visual ☐ X-ray ☐ Clinical ☐ Unknown

Diagnostic Summary (document details of physical evaluation, pathology, scopes, x-rays/scans, and lab tests including date and name of procedure(s), slide #, facility, specimen, histology, grade, behavior, tumor size, extension, surgical margins, LN's involved and examined). Attach copies of surgical or pathology reports and discharge summaries, if necessary.

Collaborative Staging

Size of Tumor _____ Describe Size _____

Extension _____

No. of Regional Lymph Nodes *Positive* _____ No. of Regional Lymph Nodes *Examined* _____

Sites of Distant Metastases _____

Substantiate Stage _____

SEER Summary Staging

☐ In-situ ☐ Local ☐ Regional ☐ Distant ☐ Unknown

AJCC Staging

☐ Clinical ☐ Pathological

T _____ N _____ M _____ Stage Group _____

TREATMENT INFORMATION

Cumulative Treatment Summary (document details of surgery, radiation, or systemic therapy including dates, places, and types; if no therapy is given, record reason)

OUTCOMES

Status

Date of Last Contact or Death _____

Vital Status ☐ Alive ☐ Dead

Cancer Status ☐ No Evidence ☐ Evidence ☐ Unknown

Cause of Death _____

Autopsy ☐ Yes ☐ No ☐ Unknown

Place of Death _____

Recurrence

Recurrence Date _____

Recurrence Type

☐ In-situ ☐ Local ☐ Regional
☐ Distant ☐ Unknown

Describe _____

Comorbidities and Complications (ICD-9-CM)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Physician – Surgeon Physician – Follow-Up Physician - Managing Physician – 3 Physician – 4

Fax to Montana Central Tumor Registry, (406) 444-6557